

Medical History

Name: _____ Date: _____

Who referred you here today? _____ Reason(s) for visit: _____
 Name: _____ How long has it been present? _____
 Address: _____ How often does it happen: _____
 Telephone: _____ What treatment(s) have you had before? _____

What medical problem are you being treated for? Who are your doctors?

Doctor:	Illness/Condition:	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you had any surgeries in the past? Who was/were the surgeons?

Doctor:	Surgery:	Phone:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have a pacemaker? _____ yes _____ No If "yes", what type? _____

What medications do you take? (Pills, ointments, vitamins, eye drops)

Do you take aspirin containing products/medications? _____ yes _____ No

Allergies: _____ None _____ Penicillin _____ Sulfa _____ Fluorecein _____ Idoine dyes _____ Shellfish
 _____ Latex _____ Maxitrol _____ Erythromycin _____ Neomycin Other, Describe: _____

Type of reaction: _____

Past Medical History: Please check any problem you have had and explain. If you have not had any problems, check "no".

General (constitutional)

Yes	No	
_____	_____	weight loss _____
_____	_____	lack of energy _____
_____	_____	trouble sleeping _____
_____	_____	problems with anesthesia _____

Eyes

Yes	No	
_____	_____	vision loss _____
_____	_____	any change in vision _____
_____	_____	eye pain _____
_____	_____	dry eye _____
_____	_____	other _____

Ears, Nose, Mouth, Throat

Yes	No	
_____	_____	hearing loss _____
_____	_____	sinus problems _____
_____	_____	infections _____
_____	_____	other _____

Lungs (respiratory)

Yes	No	
_____	_____	asthma _____
_____	_____	bronchitis _____
_____	_____	shortness of breath _____
_____	_____	tuberculosis (TB) _____
_____	_____	other _____

Stomach & Intestines (gastrointestinal)

Yes	No	
_____	_____	ulcers _____
_____	_____	diverticulitis _____
_____	_____	constipation _____
_____	_____	hepatitis _____
_____	_____	other _____

Kidneys, Bladder, Prostate, (genitourinary)

Yes	No	
_____	_____	kidney infections _____
_____	_____	urinary infections _____
_____	_____	cancer _____
_____	_____	on dialysis (list days) _____
_____	_____	other _____

Heart & Blood Vessels

Yes	No	
_____	_____	heart attack _____
_____	_____	high blood pressure _____
		how long? _____
		last check? _____
_____	_____	heart murmur _____
_____	_____	irregular heart beat _____
_____	_____	mitral valve prolapsed _____
_____	_____	chest pain _____
_____	_____	circulation problems _____
_____	_____	other _____

Nervous system & Brain

Yes	No	
_____	_____	seizure _____
_____	_____	stroke _____
_____	_____	paralysis/weakness _____
_____	_____	numbness _____
_____	_____	other _____

Mental Illness (psychiatric)

Yes	No	
_____	_____	depression _____
_____	_____	chemical imbalance _____
_____	_____	mania, bipolar _____
_____	_____	schizophrenia _____
_____	_____	other _____

Endocrine System

Yes	No	
_____	_____	diabetes _____
_____	_____	thyroid condition _____
_____	_____	other _____

Social History

What is your occupation? _____ Are you still working? _____

Do you still smoke cigarettes? _____ If "yes", how many per day? _____ For how many years? _____

Do you drink alcohol? _____ If "yes", how much? _____ For how many years? _____

Do you exercise? _____ If "yes", what kind? _____ How often? _____

Have you ever lived outside of Hawaii? _____ If "yes", where? _____ How long? _____

Past and present drug use (legal and illegal) is important for drug and anesthetic interactions. Please indicated if we need to be aware of any drug use _____ yes _____ no

Have you had a blood transfusion since 1977? _____

Family Medical History: Has any member of your family (father, mother, father's parents, mother's parents, brothers, sisters) had any of the following medical problems? Please check "yes" or "no" and list which member of your family (write down "mother" or "brother", etc.) had the problem in the space provided.

Yes	No		Yes	No	
_____	_____	diabetes _____	_____	_____	tuberculosis _____
_____	_____	thyroid disease _____	_____	_____	heart disease _____
_____	_____	stroke _____	_____	_____	high blood pressure _____
_____	_____	anemia _____	_____	_____	kidney disease _____
_____	_____	hepatitis _____	_____	_____	bleeding disorder _____
_____	_____	cancer _____	_____	_____	problems with anesthesia _____
		Type _____	_____	_____	I do not know my family history _____
_____	_____	glaucoma _____			

Is there anything not mentioned on this form you would like your doctor to know?

Signature: _____ Date: _____

Bones, Respiratory, Muscles (Musculoskeletal)

Yes	No	
_____	_____	osteoporosis _____
_____	_____	arthritis _____
_____	_____	muscle pain _____
_____	_____	other _____

Skin/Breast (Integumentary)

Yes	No	
_____	_____	Keloid scarring _____
_____	_____	rashes, sensitivities _____
_____	_____	skin cancer _____
_____	_____	breast cancer _____
_____	_____	other _____

Blood (hematologic/lymphatic)

Yes	No	
_____	_____	anemia (low blood count) _____
_____	_____	excessive bleeding _____
_____	_____	clotting problems _____
_____	_____	other _____

Allergic/Immunologic

Yes	No	
_____	_____	lupus _____
_____	_____	arthritis _____
_____	_____	HIV _____
_____	_____	other _____



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FINANCIAL POLICY

Thank you for the opportunity to serve you. We are committed to providing you with the very best care possible. The following is a statement of our financial policy that outlines patient and office financial responsibilities.

PATIENT PAYMENTS

We accept cash, checks, Visa, and MasterCard for all payments that are due on your account. Copayments are due at the time of service for all office visits. For surgery or in-office procedures that are scheduled at a later time, estimated copayments are due in full two weeks prior to the scheduled surgery or procedure date. We will provide an invoice for your review. Once your insurance company or companies have processed the claim for your office visits, you will receive a statement from our office for any applicable remaining deductibles, copayments, and the Hawaii general excise tax.

INSURANCE

Our office will file claims with your insurance company. To ensure that we have the most accurate insurance information on file, please advise our office of any changes to your insurance coverage as soon as possible. For proper billing, if you have more than one insurance policy, please provide our office with all of your insurance cards upon registration.

SELF-PAY PATIENTS

Full payment is due at the time of service. For surgery or in-office procedures that are scheduled at a later time, payment is due in full two weeks prior to the scheduled surgery or procedure date. We will provide an invoice for your review.

STATEMENTS

Regardless of any claim pending, if there is an open balance on your account, a statement may be sent to you. Any balances remaining after your insurance has made payment are due upon receipt. Please contact our office for any questions you have regarding your statement.

COLLECTIONS AND NSF CHECKS

Delinquent accounts may be forwarded to our collection agency. A collection fee of \$50 may be added to the unpaid balance to recover our costs for collection. In the event litigation is necessary, you may be liable for court costs and attorney fees as well. Our bank charges us whenever a patient presents a check that does not have funds available. As a result, we may pass along the fee of \$35 to your account.

SCHEDULING SURGERY

Surgery scheduling requires careful planning and coordination between our office, the surgery center, and their operating room staff, as well as the anesthesiologist. Estimated copayments are due in full two weeks prior to your scheduled surgery date. We will provide an invoice for your review. *You may receive a separate bill from the anesthesiologist or Queen's Same Day Surgery center for your surgery. Our office does not generate these, and any questions regarding these statements should be directed to the phone number on their bill.*

REFUNDS

All refunds will be processed in a timely matter after the overpayment is discovered on an account, or at the time the refund is requested. When cash or check was used to make payment, a refund will be issued in the form of a check. When a credit card was used to make payment, a refund will be issued back to *the same* card that was charged, if possible. When issuing the refund back to the same credit card is not possible, a refund will be made by check.

MEDICAL RECORDS

Your medical records are held with the strictest of confidence. If you request a copy of your records to be sent to another physician or to yourself, a written authorization is required. Only the requested records will be forwarded. When bringing in another physician's records to our office, you may want to consider keeping a copy for yourself.

FORM COMPLETION

Forms you need our office to complete may be subject to a fee, depending on complexity.

I hereby give my consent for The Oculoplastics Center to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations. With this consent, The Oculoplastics Center and staff may call my home or alternative locations (as listed on my registration form) and leave a message on voicemail or in person in reference to any items that assist the office in carrying out treatment, payment, and healthcare operations, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory and/or pertinent results. The Oculoplastics Center may mail to my home or other alternative locations (as listed on my registration form) any items that assist the office in carrying out treatment, payment, and healthcare operations, such as surgery packets and patient statements. By signing below, I acknowledge that I have read and understand the information presented above and wish to receive treatment and services from The Oculoplastics Center. I agree to be fully responsible for any and all charges for services rendered.

We welcome the opportunity to answer any questions that you may have in regards to our financial policies. It is our goal to ensure that patients have the best possible care during their visits to our office.

PRINT NAME _____ DATE OF BIRTH _____

PATIENT SIGNATURE (OR PARENT/GUARDIAN) _____

DATE _____

I have provided the patient with this document and answered any questions that he/she had in regard to what is stated above. _____

Employee Initials/Date